EXHIBIT 15

MAXOR[SM]
National Pharmacy Services Corp.

March 15, 2007

John Hagar
Chief of Staff
Office of the California Prison Receiver
450 Golden Gate Avenue
Law Library, 18th Floor
San Francisco, CA 94102

Re: California Department of General Services

Dear Mr. Hagar:

As Project Manager for the Receiver's CDCR pharmacy improvement initiative, I believe it is important to provide you an update on the status of Maxor's interaction with the Department of General Services (DGS). We have met with various DGS staff on 6 occasions—1/11/2007, the morning of 2/7/2007 (meeting included the Receiver's Chief of Staff), the afternoon of 2/7/2007, 2/22/2007, 3/1/2007 and 3/14/2007, and at this time, I offer the following facts, observations and opinions:

1. **Access to DGS contracts has been limited, incomplete and delayed; and a review of the contracts clearly indicate a need for improvement.**

Requests have been made since January 11, 2007 for complete copies all contracts for pharmaceuticals in which the CDCR participates. Some four weeks later, February 14, 2007, we received a list of the contracts. The complete (according to DGS officials) contracts were supplied to Maxor on February 16, 2007. Those contracts included three signed contracts (Roche, Astra Zeneca, and Lilly) by DGS, three notice of contracts awards with their attached requests for proposals (McKesson, Major and Apotex) completed in December 2006, the GPO agreement (General Purchasing Organization, officially entitled the Massachusetts Alliance for State Pharmaceutical Buying) with an accompanying MOU (Memorandum of Understanding) for

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administration by Managed Health Care Associates (MHA); and, the contract for AmeriSource Bergen, the general wholesaler managing the purchases. The AmeriSource Bergen contract provided proved to be incomplete, as discovered during a later review of a proposed contract amendment, and after a Maxor request to DGS, the missing appendices were provided February 20, 2007—now 6 weeks after our initial requests for complete contracts.

Failure to deliver the completed contracts to Maxor is important because:

1. The wholesaler stocks items and ensures timely delivery of those items to the facilities. The prices are generally set by the GPO, which, in most cases, has acceptable negotiated pricing for medications, but which may be improved through direct negotiations with individual manufacturers—both brand and generic. In the case of California, one GPO is utilized and supplemented by three brand manufacturer contracts and three generic wholesale house "contracts." This delay has prevented Maxor from monitoring and ensuring accurate pricing of pharmaceuticals for CDCR patients for at least 2 months. Monthly expenditures for CDCR medications, on the average, approximates $16 million, and, continued unfettered monitoring of accurate charges to CDCR amounts to continued months of potential savings.
2. Separate contracts negotiated by DGS (who has, in this case, instructed the wholesaler to load the negotiated prices first, rather than taking the best price available at the time of procurement) can provide substantial savings ***if such contracts are based on clinical need*** within a therapeutic class of medications. However, in the case of DGS contract management for CDCR purchases, there ***does not appear to be a concerted effort to identify the clinical need,*** nor associate it with a disease specific treatment guideline. This lack of effort is not surprising since DGS Pharmacy and Therapeutics Committee operates outside of the CDCR and has representatives from multiple state agencies, each with their own, individual needs.
3. Initial analysis of the contracts also noted that:
    - The three notice of contracts (McKesson, Major and Apotex) were signed 12/11/2006, and represent primarily suppliers of generic medications. In our opinion, these contracts represent equivocal long term savings to the State of California.
    - The three signed contracts (Roche, Astra Zeneca, and Lilly), while providing a reduction in pricing for three select brand medications,

contain terms we find unacceptable. For instance, these contracts assure free access on the CDCR Formulary with no restrictions to practitioners at a time when there was only one available clinical disease management guideline to assist practitioners in the appropriate utilization of one of these medications. In all probability, clinical practice was influenced by Formulary decisions outside of CDCR review.

2. **DGS has shown a lack of responsiveness to CDCR patient specific needs.**

Maxor and DGS have participated in six meetings with DGS officials on 1/11/2007, 2/7/2007 morning, 2/7/2007 afternoon, 2/22/2007, 3/1/2007 and 3/14/2007. Discussions have centered on the role of the reconstituted CDCR Pharmacy and Therapeutics Committee and the resultant role of the DGS sponsored Pharmacy and Therapeutics Committee and the Common Drug Formulary. From our initial meetings, Maxor has emphasized the need for an appropriate, correctional-based Pharmacy and Therapeutics Committee to deal with the unique situations, circumstances and patient populations in the correctional setting. During this process, DGS has requested assistance with one immediate contracting need (reclamation) and has proposed a revised "business proposal agreement" for vendors wishing to enter into negotiations concerning specific pharmaceutical items. DGS has requested a schedule of the therapeutic category reviews. That schedule was provided during a meeting on 3/13/2007 to DGS officials.

In our opinion, these meetings have devoted ***too much time to too little process resolution, and DGS continues to be unresponsive to current CDCR medication needs***. In our opinion, DGS should be, at a minimum, actively monitoring medication expenditures within CDCR and designing strategies responsive to CDCR patient needs. After careful study of those needs, DGS should be aggressively seeking more favorable pricing for known patterns of drug utilization pending further guidance from the CDCR Pharmacy and Therapeutics Committee, in the way of Disease Management Guidelines and Therapeutic Category Reviews.

3. **DGS continues to negotiate contractual terms without adequately considering input on CDCR-specific needs.**

DGS continues to request proposals and negotiate terms of contracts with various vendors since Maxor's contract initiation without regard to the utilization and need of CDCR patients and the direct inclusion of Maxor in those negotiations. ***Release of information from DGS to Maxor continues to be partial, and continued questions of confidentiality are invoked at every stage of the process.*** Of particular note is the upcoming expiration of the Roche contract. DGS stated in our most recent meeting that negotiations were occurring, yet details (conditions) could not be released due to confidentiality concerns that Maxor was not included in the original request for business proposal prepared by DGS.

In our opinion, the continued negotiations for contracts without regard to CDCR utilization, and the exclusion of Maxor from the negotiating table represents a serious obstacle to our effective and efficient management of the procurement, distribution and the resultant prescriptive practices within the CDCR.

4. **DGS Confidentiality Concerns Are Impeding Progress**

Maxor received verbal approval from the Receiver's Chief of Staff on February 7, 2007 to allow the Heinz Family Philanthropies to conduct an analysis of 340B pricing for the CDCR at no charge. This organization is committed to helping governmental entities address dwindling resources and increased demands. One of efforts that the organization has supported is 340B pricing—that is, medication pricing to disproportionate populations served by an entity. Designation as such an entity is not without multiple hurdles. The Heinz Family Philanthropies expertly evaluates the setting, estimates cost savings, and delineates the challenges to achieving 340B designation that the health care entity must overcome. Maxor internally estimates those savings to approximate $62 million annually for the CDCR population. It is our continued belief that such an evaluation by a reputable outside source would be of benefit to the state.

Maxor verbally requested from DGS on 2/7/2007 permission to release purchase data in an aggregate fashion to the Heinz Family Philanthropies—release of information in this manner does not release specific contractual pricing information, but rather combines multiple medications with similar, industry accepted grouping categories into a single group thus prohibiting specific drug

price identification. Because of prior contractual obligations to three vendors, DGS has chosen not to provide Maxor permission to release that data; choosing instead to supply these three vendors with letters of introduction to Maxor and requesting that we discuss the study with them individually.

In our opinion, these contracts were made by DGS, are administered by DGS and any concerns releasing the aggregate data is a direct byproduct of DGS decisions in their poorly conceived contractual negotiations. In actuality, no current vendors contracted by DGS have a compelling interest in participating in such a study—should 340B pricing become available, it could potentially reduce vendor pricing by 30%. As of 3/7/2007, this impasse has not been resolved—DGS continues to delay permission to release of the data. We should be allowed to engage the Heinz Family Philanthropies immediately and provide them with the aggregate data needed to conduct the analysis. Each day that the 340B pricing is not realized could represent a potential savings in excess of $160,000 daily in providing medications to patients in CDCR.

DGS continues to present obstacles to the accomplishment of our project's objectives through limited access to contract negotiations, repeated assertions of prior confidentiality requirements, and restricted access to certain medications for CDCR patients without regard to current utilization and existent disease management guidelines. In this way, we believe that DGS seriously impedes access of inmate patients to the benefits and safeguards of contemporary pharmacy management systems, including effective and cost savings procurement procedures, distribution and contemporary disease management processes. As a result, Maxor requests that we be allowed to become the contract negotiator under the purview of the CPR contracting office for CDCR pharmaceuticals procurement. Only in this way can we assure a timely and responsive system to CDCR patient needs given the current state of DGS responsiveness.

Glenn G. Johnson, M.D.
Maxor CPR Project Manager